Evidence for change of cause of death is shown on FILM No. G 94 APR 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

00386

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 16 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: Not a veteran

3.(a) FULL NAME: William Jesse Bowden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Lowell Edna Bowden
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): July 3 1919

8. AGE: Years	Months	Days	If less than one day
25	6	22	...hrs. ...min.

9. Birthplace: North East, Cecil Co. Md
(Town, county, and state)
10. Usual occupation: Deck Hand.
11. Industry or business: Dredge
FATHER 12. Name: Walter H. Bowden
13. Birthplace: Md
MOTHER 14. Maiden name: Grace E. Phillips
15. Birthplace: Md
16. Informant: Mrs. Walter Bowden
Address: RD. North East, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 28 1945 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: North East, Md.
16. Funeral director: Joseph R. Grant
Address: North East, Md.
19. Jan 26 1945 (Date rec'd by registrar) F H Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 28 1945, at 1 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to Jan 28, 1945, and that I last saw him alive on Jan 25, 1945

	DURATION
Immediate cause of death: Starvation & accidents	
Due to: Carcinoma of Neck & Throat	1 years
Due to: Primary Carcinoma of neck.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. William Campbell M.D.
M. D. or other
Address: North East, Md. Date signed: Jan 26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

00387

Reg. Dist. No. 90

1. PLACE OF DEATH:

County: Cecil

City or town: Warwick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Warwick Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME — William J. Boyles —

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie E. Taylor

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE:

Years	Months	Days	If less than one day
65			hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: James Boyles

13. Birthplace: Del.

MOTHER — 14. Maiden name: Annie Rose

15. Birthplace: Del.

16. Informant: Mrs Annie E. Boyles

Address: Warwick Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-12-45 (month) (day) (year)

Cemetery or crematory: Warwick cemetary

Location: Warwick Md.

18. Funeral director: G. Luter Daniels

Address: Townsend Del.

19. Jan. 12 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 8 / 45 19 ..., at ... M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1942 19 ..., to Jan 8 19 45

and that I last saw h.. alive on Jan 8 / 45 19

Immediate cause of death	DURATION
1. Coronary Artery Disease	2 years
Antecedent 2. Coronary Occlusion	12 hrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Walter H. Lee M.D.

M. D. or other

Address: Middletown Date signed 1/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

00388

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 days

Hospital, Institution, or street address where death occurred: Union Hosp

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: North East, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Roy Briscoe

3.(b) Social Security Number: 219-10-8736

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Mamie Briscoe

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: 54 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Elk Neck Cecil Co Md

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Dynamite Explosives

FATHER — 12. Name: Joseph Briscoe

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Emma Roberts

MOTHER — 15. Birthplace: Md

16. Informant: Mrs Roy Briscoe

Address: North East Md

17. (Burial, cremation, or removal. Which?) Buried Date thereof: Jan 23 1945 (month) (day) (year)

Cemetery or crematory: St Marks A.M.E.

Location: North East Rural Md

18. Funeral director: Joseph R Stuart

Address: North East Md

19. (Date rec'd by registrar) Jan 22 1945 H A Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 19 1945 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1945 to Jan 19 1945 and that I last saw h alive on Jan 19 1945

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions: Extreme hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. T. Morrison, M.D. M. D. or other

Address: Elkton, Md Date signed 1-22-45

Evidence for change of age of deceased is shown on FILM No. G 92 MAR 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00389

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: Bainbridge, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ months

Hospital, Institution, or street address where death occurred: US Naval Hospital, NavTraCenter, Bainbridge, Md.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Oklahoma County: Osage

City or town: Tulsa
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2244 East 10th Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WORLD WAR II ✓

3.(a) FULL NAME: David Byron B R O C K

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Not married

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7/23/26

8. AGE: Years	Months	Days	If less than one day
18 ~~17~~	5	27	..... hrs. ..... min.

9. Birthplace: Tulsa Oklahoma
(Town, county, and state)

10. Usual occupation: US Navy

11. Industry or business

FATHER 12. Name: Ray Clifford BROCK

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: US Naval Hospital NavTraCenter

Address: Bainbridge, Maryland.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan. 25 1945 (month) (day) (year)

Cemetery or crematory: To Ninde Funeral Home

Location: Tulsa, Oklahoma

19. Funeral director: Leza Patterson & Son

Address: Perryville, Md.

19. Jan. 25 1945 (Date rec'd by registrar) James E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 January 1945, at 7³⁴ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 January 1945 to 23 January 1945 and that I last saw h.i.m.a. alive on 23 January 1945

Immediate cause of death	DURATION
Pneumonitis, Acute, Hemorrhagic	24-36 hrs.
Due to: Streptococcus	
Due to:	
Other conditions: Peritonitis, general, acute, Early.	18 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations: No gross evidence of peritonitis at operation. Date of op. 23 Jan. '45

Autopsy results: Diffuse Hemorrhagic Pneumonitis, early, peritonitis.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industrial or public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. B. McGraw, Comdr. (MC)-USNR M. D. or other

Address: U.S. Naval Hospital Bainbridge, Md. Date signed 23 Jan. '45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

0390

Reg. Diat. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: North East Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME William A Cameron

3.(b) Social Security Number 220-09-5209

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Sarah R. Weaver

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Feb. 7 - 1867

8. AGE: Years	Months	Days	If less than one day
77	11	18	...hrs. ...min.

9. Birthplace: North East Cecil Co. Md.

(Town, county, and state)

10. Usual occupation: Watchman

11. Industry or business: Erie Brick Co -

FATHER

12. Name: James M. Cameron

13. Birthplace: Pa

MOTHER

14. Maiden name: Margaret Baker

15. Birthplace: Pa -

16. Informant: Mrs Sarah Cameron

Address: North East R D Md -

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 29 1945 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: North East, Md -

18. Funeral director: Joseph R. Grant

Address: North East, Md -

19. Jan 29 1945 (Date rec'd by registrar) Lida V. Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25 1945, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary	
Due to: Thrombosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R E Dodson MD Medical Examiner for Cecil County

M. D. or other

Address: Penn Lew MD Date signed: 1-26-45

Evidence for change of age of deceased is shown on FILM No. G 92 MAR 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 306

CERTIFICATE OF DEATH

00391

Reg. Diat. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 322 days
Hospital, institution, or street address where death occurred: Veterans Administration, Perry Point, Md.
How long in hospital or institution? 322 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1532 S. 11th Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I ✓

3. (a) FULL NAME: CARTER, Amzie L.

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 5, 1896

8. AGE: Years	Months	Days	If less than one day
48 ~~58~~	10	16	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: --

FATHER
12. Name: James Carter
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Superner Rolands
15. Birthplace: Washington, D. C.

16. Informant: Records - Veterans Administration,
Address: Perry point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: January 23, 1945 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Fort Myer, Virginia

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Jan 23 1945 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21 1945 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1944 to January 21 1945 and that I last saw him alive on January 21 1945

Immediate cause of death	DURATION
Cenneral Paralysis of the Insane	10 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, Lt. Col., MC, (M. D.) or other
Address: Veterans Administration Perry Point, Md. Date signed 1-23-45 Director

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-2

CERTIFICATE OF DEATH

00392

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 1 day

Hospital, institution, or street address where death occurred: Veterans Administration, Perry Point, Md.

How long in hospital or institution? 3 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Delaware County: New Castle

City or town: Minquadale

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Hazel & Delaware Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3. (a) FULL NAME: CHAIRS, Thomas J.

3. (b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Eva M. ? Chairs

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): March, 1898

8. AGE: Years	Months	Days	If less than one day
46	10	?	– hrs. – min.

9. Birthplace: Denton, Md. (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: "

FATHER — 12. Name: Thomas Chairs

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: First name unknown - Elliott

MOTHER — 15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-19-45 (month) (day) (year)

Cemetery or crematory: Gracelawn Memorial Cemetery

Location: 3202 Market Street, Wilmington, Del.

18. Funeral director: Pennington & Son PENNINGTON & SON

Address: Havre de Grace, Md.

19. Jan 19 19 45 (Date rec'd by registrar) Irma E. Daylett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18 19 45, at 9:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17 19 44, to January 18 19 44

and that I last saw him alive on January 18 19 44

Immediate cause of death	DURATION
Central Nervous System Lues,	
Meningo-encephaletic type	Over 4 yrs.
Due to	
Due to	
Other conditions: Psychosis with central nervous system lues, Meningo-encephaletic type	Over 8 Mo.

(Include pregnancy within 3 months of death)

Major findings of operations: –

Date of op. –

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: – Date of –

Where did injury occur? – (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) –

Means of injury: Injured at work? –

23. SIGNATURE: A. E. Boeckmann M. D., or other

Clinical Director, Veterans Administration

Address: Perry Point, Md. Date signed 1-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00393

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 mos.
Hospital, institution, or street address where death occurred: Mrs Boop. Elkton.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Leroy Earl Cole.

3.(b) Social Security Number: 233-22-7830

4. Sex: M.
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Edith Cole
6.(c) If alive, give age: 32 years
7. Birth date of deceased (mo., day, yr.): June 9 - 1909
8. AGE: Years: 35 Months: 7 Days: 3 If less than one day: hrs. min.
9. Birthplace: Hanley W. Virginia (Town, county, and state)
10. Usual occupation: Defense Worker
11. Industry or business

FATHER
12. Name: Aaron Cole
13. Birthplace: Hanley Bridge Virginia

MOTHER
14. Maiden name: Pink Valentine
15. Birthplace: Hanley W. Virginia

16. Informant: Mrs Edith Cole
Address: Gen. Reed Village Newark Del

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan 15. 45 (month) (day) (year)
Cemetery or crematory: Hanley
Location: West Virginia
18. Funeral director: R. T. Jones
Address: Newark Del.

19. Jan 13 1945 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12 1945 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Cardiac Collapse.	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. H. Dodson M.D. Medical Examiner Cecil County
M. D. or other
Address: Elkton Md Date signed: 1-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-2)

CERTIFICATE OF DEATH

06394

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr, 7 mo. 24 da.

Hospital, institution, or street address where death occurred: Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County: Allegheny

City or town: Wilkinsburg, Pa.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 246 Highland Road

(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I ✓

3. (a) FULL NAME ALLEN E. CONNOLLY

3. (b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): 2-2-1880

8. AGE:

Years	Months	Days	If less than one day
64	11	11	– hrs. – min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business: –

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Ireland

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-15-45 (month) (day) (year)

Cemetery or crematory: Homewood Cemetery

Location: Pittsburgh, Pa.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. Jan. 15 1945 (Date rec'd by registrar) Irma E. Dengler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Janury 13 1945, at 2:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 1943, to January 13 1945

and that I last saw her alive on January 13 1945

Immediate cause of death: Cerebral Thrombosis, with softening — DURATION: 3 yrs. 8 mo.

Due to: Arteriosclerosis, cerebral — DURATION: 3 yr. 8 mo.

Due to: –

Other conditions: Arteriosclerosis, coronary — Undetermined

Arteriosclerosis, general — "

(Include pregnancy within 3 months of death)

Psychosis with cerebral arteriosclerosis

Major findings of operations: – Date of op.: Undet.

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: – Date of: –

Where did injury occur? – (City or town) – (County) – (State)

Injured at home, farm, industry, public place (where?): –

Means of injury: – Injured at work? –

23. SIGNATURE: L. E. Trollinger

L. TROLLINGER, Col. M.C. M.D. or other

Clinical Director, Lt. Veterans Adm.

Address: Perry Point, Md. Date signed 1-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

00395

CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Cecil
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 da.
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 5 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Chesapeake City, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Capt. Charles W. Cooling.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Married

6.(b) Name of husband or wife: Mary E. Cooling
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): February 13, 1878

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace: Chesapeake City, Md. (Town, county, and state)
10. Usual occupation: Boat Captain
11. Industry or business
FATHER 12. Name: Zachary Cooling
13. Birthplace: Charlestown, Md.
MOTHER 14. Maiden name: Josephine E. Towells.
15. Birthplace: New Jersey.
16. Informant: Mrs. Mary E. Cooling
Address: Chesapeake City, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 18, 1945 (month) (day) (year)
Cemetery or crematory: Bethel
Location: Near Chesapeake City, Md.
18. Funeral director: H. W. Pippin
Address: Elkton, Md.
19. June 18 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14 1945, at 2 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1945, to June 14 1945
and that I last saw h... alive on June 14 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation	5 hours
Due to Chronic myocarditis	—
Due to Coronary sclerosis	—
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jas. J. Hennessy M.D.
M. D. or other
Address: Elkton Date signed: June 17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00396

CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Cecil
County
City or town Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 75 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alexander Craig

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Jennie Ward Craig
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1849

8. AGE: Years	Months	Days	If less than one day
95	7	2	hrs. min.

9. Birthplace Cecil Co. Md
(Town, county, and state)
10. Usual occupation Yard Master (Retired)
11. Industry or business Penna. R. R.

FATHER
12. Name Victor Craig
13. Birthplace Cecil Co. Md

MOTHER
14. Maiden name Margaret Gibson
15. Birthplace Cecil Co. Md

18. Informant Jennie Ward Craig
Address Perryville, Md

17. Burial
(Burial, cremation, or removal (Which?)) Date thereof Jan. 13 1945
(month) (day) (year)
Cemetery or crematory Charlestown
Location Charlestown, Cecil Co. Md.

18. Funeral director Lee A. Patterson & Son
Address Perryville, Md.

19. Jan 13 1945 Jennie E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10th 1945, at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1st 1944, to January 10 1945
and that I last saw him alive on January 8 1945

Immediate cause of death	DURATION
General atheromata	2
Due to Infirmities of age	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. F. Magraw
M. D. or other
Address Perryville Md Date signed 1-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (no-c)

00397

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Bainbridge, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 - 1/2 months

Hospital, institution, or street address where death occurred:
Bainbridge, Maryland. NavHosp. NavTraCen.

How long in hospital or institution? 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County: ---

City or town: Freeland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1100 Gale St.
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. II

3. (a) FULL NAME: DINOFRIO, Joseph Anthony

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Not Married

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 30 June 1919

8. AGE: Years	Months	Days	If less than one day
25	6	2	..... hrs. ..... min.

9. Birthplace: Freeland, Penna.
(Town, county, and state)

10. Usual occupation: U.S. Navy

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: U.S. NavHospital, NavTraCen
Address: BAINBRIDGE MARYLAND

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan. 4, 1945 (month) (day) (year)

Cemetery or crematory:
Location: To Freeland, Luzerne co., Pa.

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. Jan. 3 1945 (Date rec'd by registrar) Irene E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 January 1945, at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on 2 January 1945

Immediate cause of death	DURATION
Injuries Multiple Extreme	25 min.
Due to: Auto accident	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~ Date of 1/2/45

Where did injury occur? Aiken, (City or town) Cecil (County) Md. (State)

Injured at home, farm, industry, public place (where?) rural

Means of injury: ..... Injured at work? .....

23. SIGNATURE: R. E. Dodson M.D. Medical Examiner for Cecil County
M. D. or other

Address: Rising Sun Md. Date signed 1-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

00398

Reg. Diat. No. 94

1. PLACE OF DEATH

County: Cecil

City or town: North East
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State: Maryland County: Cecil

City or town: North East Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Nellie Blanche Dunlap

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Samuel Dunlap

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1 1872

8. AGE: Years	Months	Days	If less than one day
72	10	1	hrs. min.

9. Birthplace: North East Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Charles W Grant

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Catherine Adams

15. Birthplace: Md

16. Informant: Helen Biddle

Address: North East Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-5-45 (month) (day) (year)

Cemetery or crematory: Methodist

Location: North East, Md

18. Funeral director: Joseph R Grant

Address: North East Md

19. 1-5-45 (Date rec'd by registrar) Leda L Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 2 1945, at 9.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944 to Jan 2 1945 and that I last saw h. alive on Dec. 30 1944

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Cardio-vascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dr. W. Lowe Ley M.D. or other

Address: Elkton Date signed: Jan 5, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

00399

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Union Hospital Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hospital 5 mnths

How long in hospital or institution? 5 wk

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Charey Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Alexander Harrigan

3.(b) Social Security Number 217-09-8939

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Laura Mae Harrigan

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Oct 24 - 1883

8. AGE:

Years	Months	Days	If less than one day
61	2	15	...hrs. ...min.

9. Birthplace: Fair Hill Cecil Co Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Robert Alexander Harrigan

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary Ellen Carr

15. Birthplace: Maryland

16. Informant: Mrs. Laura Harrigan

Address: Elkton R. D. 5 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 11-1945 (month) (day) (year)

Cemetery or crematory: Charey Hill Cemetery

Location: Charey Hill Cecil Co Md

18. Funeral director: Clarence E Abramshire

Address: Elkton R.D. 5 Md

19. Jan 10 1945 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8 1945 at 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1944 to Jan 8 1945 and that I last saw h... alive on Jan 8 1945

Immediate cause of death	DURATION
Carcinoma of rectum with gnaral metastasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of rectum Hypertrophy of prostate Date of op. Dec 5-1944

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J Herbert Bell M.D. M. D. or other

Address: Elkton Md Date signed: 1/9/45

M

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00400

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Margaret R. Harvey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Harry L Harvey

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.): Jan 5 1879

8. AGE:

Years	Months	Days	If less than one day
66	—	16	..... hrs. ..... min.

9. Birthplace: Baltimore City, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER

12. Name: Aldridge P. Reynolds

13. Birthplace: North East, Md.

MOTHER

14. Maiden name: Matilda E Dodson

15. Birthplace: Northumberland Co. Virginia

16. Informant: Miss Elizabeth Harvey

Address: North East, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 24 1945 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: North East, Md.

18. Funeral director: Joseph R. Grant

Address: North East, Md.

19. Jan 24 1945 (Date rec'd by registrar) Lida V Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 21 1945 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County

M. D. or officer

Address: Elkton, Md. Date signed: 1/23-45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00491

Reg. Dist. No. 9C

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa County: Lackawanna
City or town: Scranton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 346 Birch
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #II

3.(a) FULL NAME: Charles Peter Huester

3.(b) Social Security Number: 578-22-6629

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Widower

6.(b) Name of husband or wife: Edna Huester
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 22 1893

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
51	1	24		

9. Birthplace: Scranton Pa.
(Town, county, and state)
10. Usual occupation: Policeman
11. Industry or business:

FATHER
12. Name: Charles Huester
13. Birthplace: Germany

MOTHER
14. Maiden name: Arabella Shue
15. Birthplace: Albany N.Y.

16. Informant: Clara M. Huester
Address: Elkton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 17 1945 (month) (day) (year)
Cemetery or crematory: Hickory St. Presbyterian
Location: Scranton, Pa.

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. Jan. 17 1945 (Date rec'd by registrar) Irene E. Mayfield Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 15 1945, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Coronary	
Due to: Thrombosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County
Address: Elkton Md. M. D. or other
Date signed: 1-16-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00402

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 4 da.

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? 1 mo. 4 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town: Box 291, Rt. 16, Balto., 21.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I

3.(a) FULL NAME: HUNTER, John F.

3.(b) Social Security Number: 217-01-1739

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ////// Mrs. Agnes (Maiden name unknown)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 23, 1888

8. AGE: Years	Months	Days	If less than one day
56	-	27	— hrs. — min.

9. Birthplace: Peckville, Pa. (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: -

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Hospital records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: January 19, 1945 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery, Annapolis, Md.

Location: Annapolis, Md.

18. Funeral director: B.L. Hopping B.L. Hopping

Address: 170 West St., Annapolis, Md.

19. Jan. 19 1945 (Date rec'd by registrar) Irene E. Dunlop Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1945, at 10:15A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1944, to January 19 1945; and that I last saw him alive on January 19 1945

Immediate cause of death	DURATION
Central Nervous System Lues, Meningo encephalitic type	Over 5 yrs.
Due to: //// Bronchitis, chronic	Unknown
Due to: Pleurisy, rt. lower chest	Unknown
Due to:	
Other conditions: Psychosis with syphilis of Central Nervous System, Meningo-encephalitic type. (Include pregnancy within 3 months of death)	3 months

Major findings of operations: —

Date of op. —

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) 0 (State)

Injured at home, farm, industry, public place (where?): —

Means of injury — Injured at work? —

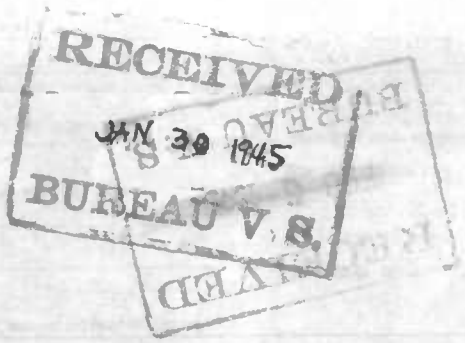
23. SIGNATURE: A.E. Drollinger

A.E. Drollinger, Lt. Col., M.C. (M.D., or other)
Chief Director
Address: Veterans Administration, Date signed: 1-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
JAN 30 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (79-4)

CERTIFICATE OF DEATH

00402

Reg. Dist. No. 90

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Warwick Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 Yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Warwick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ethel Jenkins

3. (b) Social Security Number:

4. Sex	5. Color or race	5.(a) Single, married, widowed, or divorced
Female	Col. American	Married

6.(b) Name of husband or wife: Emanuel Jenkins

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Sept 9, 1903

8. AGE: Years	Months	Days	If less than one day
41			hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER 12. Name: William A Rhoads

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Irene Hudge

MOTHER 15. Birthplace: Maryland

16. Informant: Emanuel Jenkins

Address: Warwick Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 1 1945 (month) (day) (year)

Cemetery or crematory: Lakes Cemetery

Location: Middletown Del

18. Funeral director: Edw R Bell

Address: 904 Poplar Street

19. Feb 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29 1945, at 9 30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1943, to January 29 1945 and that I last saw h. E.J. alive on January 29 1945

Immediate cause of death	DURATION
Myocardial Failure	2 mos
Due to: Malignant Hypertension	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel G. Elbert Jr MD

M. D. or other

Address: 1000 Fremont St Wilmington Dela Date signed: Feb 6, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

00484

Reg. Diat. No. 95

1. PLACE OF DEATH:

County: Cecil

City or town: Outside Conowingo

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Outside Conowingo

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George W. Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Harriet Jones.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 12, 1870

8. AGE: Years: 70 | Months: 7 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Conowingo Cecil Co. Md.

(Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER — 12. Name: George P. Jones

FATHER — 13. Birthplace: Conowingo. Md.

MOTHER — 14. Maiden name: Mary Boddy

MOTHER — 15. Birthplace: Conowingo. Md.

16. Informant: Mary Jones

Address: Conowingo Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 28 1945 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Conowingo Md.

18. Funeral director: J. E. Tyson

Address: Rising Sun Md

Jan. 26 1945 (Date rec'd by registrar) H M Worthington (Signature of Registrar)

Permit issued 1-26-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 23 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1945 to Jan 23 1945 and that I last saw h... alive on Jan 16 1945

Immediate cause of death	DURATION
Edema	
Myocarditis	
Due to	
Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Allen Wilson M.D. M. D. or other

Address: Rising Sun Md. Date signed: 1-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of cause of death is shown on FILM No. G 9 4 APR 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-a

CERTIFICATE OF DEATH

00405

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna L Keys

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Jonathan Keys

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 15 1863

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
81	8	30		

9. Birthplace: Chester Co. Penn. (Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER

12. Name: unknown

13. Birthplace

MOTHER

14. Maiden name: unknown

15. Birthplace

16. Informant: Mrs Rachel Ferguson

Address: North East, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 16 1945 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: North East, Md

19. Funeral director: Joseph R. Grant

Address: North East, Md

19. Jan 16 1945 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1945, at 8.50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3, 1945 to Jan 13, 1945 and that I last saw h[illegible] alive on Jan 12, 1945

Immediate cause of death	DURATION
Fracture left Elbow & Shock	
Due to: Accidental fall. cause	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At her home

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: [illegible] Caldwell M.D.

M. D. or other

Address: North East Md Date signed: Jan 13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00406

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Port Deposit road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Robert A. Kirk

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: M. Pauline Kirk
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1870

8. AGE:

Years	Months	Days	If less than one day
74	2	23	hrs. min.

9. Birthplace: Port Deposit Cecil co. md
(Town, county, and state)
10. Usual occupation: Mail Clerk.
11. Industry or business: U.S.P.O.
FATHER
12. Name: Allen E. Kirk
13. Birthplace: Cecil co. md
MOTHER
14. Maiden name: Mary Agnes Aiken
15. Birthplace: Cecil co., md
16. Informant: M. Pauline Kirk
Address: Perryville, Md. Rural
17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan 28 1945 (month) (day) (year)
Cemetery or crematory: St Francis.
Location: Warwick, cecil co. md
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Jan. 27 1945 Irene E Douglass Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25 1945 at 12:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10 1944 to Jan 25 1945
and that I last saw h[illegible] alive on Jan 22 1945

Immediate cause of death	DURATION
Uremia Edema	
Hypertension	
Due to: Cerebral Hemorrhage	
Due to:	
Other conditions: Pneumonia Fatal	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M. D.
M. D. or other
Address: Havre de Grace Date signed: 1/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00407

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs. 3 mo. 1 da.
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: 3401 Porter Street, N.W.
(If outside city or town limits, write RURAL and give nearest town)
Washington, D.C.
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME: LEE, James C.

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): September 5, 1895

8. AGE: Years	Months	Days	If less than one day
49	4	22	- hrs. - min.

9. Birthplace: Norfolk Co., Va.
(Town, county, and otate)

10. Usual occupation: Laborer

11. Indostry or business: -

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 30, 1945. (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

18. Funeral director: Runnymede Inc
Address: Havre de Grace, Md.

19. Jan 30 19 45 (Date rec'd by registrar) Irene E. Hendrickson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27 19 45 at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 16 19 39 to January 27 19 45 and that I last saw him alive on January 27 19 45

Immediate cause of death	DURATION
Abscess, lung, right	Unknown
Due to: Carcinoma, tongue	7 mo.
Due to:	Over
Other conditions: Dementia Precox, Hebephrenic	6 yrs.
Syphilis, latent	over 6 yrs.

(Incinde pregnancy within 3 months of death)

Major findings of operations: - Date of op.: -

Antopsy results: Same as above

PHYSICIAN: Please nnderlioe the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? - (City or town) - (Connty) - (State)
Injured at bome, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: A. E. HOLLINGER, Lt. Col., M.C. M. D. or other
Clinical Director, Veterans Administration
Address: Perry Point, Md. Date signed: 1-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of cause of death is shown on FILM No. G 9 4 APR 7 1945

00498

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

Reg. Dist. No. 95

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Outside Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Outside Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth McCummings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Loraine McCummings
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 2, 1864

8. AGE: Years	Months	Days	If less than one day
80	4	8	..... hrs. ..... min.

9. Birthplace: Cecil Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Thomas Taylor
13. Birthplace: Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Arthur McCummings
Address: Rising Sun, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13 1945 (month) (day) (year)
Cemetery or crematory: Brookview
Location: Rising Sun Md.

18. Funeral director: J. E. Tyson,
Address: Rising Sun Md.

19. Jan 11 1945 (Date rec'd by registrar) L M Worthington Registrar
Permit issued 1-11-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 10 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 2 1945 to Jan 10 1945
and that I last saw h... alive on Jan. 5 1945

Immediate cause of death	DURATION
Malnutrition & Myocarditis.	
Due to: Chronic myocarditis; several years	
Due to:	
Other conditions: Age and feeble mind.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D.
M. D. or other
Address: Rising Sun Md. Date signed 1-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

00469

Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs. 14 da.

Hospital, Institution, or street address where death occurred: Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: N.C. County: Caldwell

City or town: Lenoir
(If outside city or town limits, write RURAL and give nearest town)

Street No.: P.O Box 108
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American ✓

3. (a) FULL NAME: HENRY CLIVER MELTON

3. (b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ////// Maiden name unknown

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): November 9, 1866

8. AGE: Years	Months	Days	If less than one day
78	2	4	– hrs. – min.

9. Birthplace: LENoir, N.C. (Town, county, and state)

10. Usual occupation: Lumber and contracting

11. Industry or business: –

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: Hospital records

Address: Veterans Administration, Perry Point, Md.

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) (day) (year) 1-15-45

Cemetery or crematory: ////// Moriah's Chapel Cemetery

Location: Yadkin, N.C.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. (Date rec'd by registrar) Jan. 15 19 45 Irma E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 19 45 at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 30 19 30, to 1-13-45 19 ; and that I last saw him alive on January 13 19 45

Immediate cause of death	DURATION
Chronic Myocarditis, with myocardial degeneration	Over 7 yrs.
Due to: Arteriosclerosis, coronary	" "
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis	14 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: –

Date of op.: –

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: – Injured at work? –

23. SIGNATURE: A. B. Isaacman, M. D. or other

Address: Perry Point, Md. Clinical Director, Veterans Administration Date signed: 1-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00410

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Elktown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life 9 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Larson Harvell.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Widowed

6.(b) Name of husband or wife: Effie Harvell, deceased
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug 3, 1868

8. AGE: Years	Months	Days	If less than one day
76	5	26	hrs. min.

9. Birthplace: Cecil Co., Md (Town, county, and state)
10. Usual occupation: Track Foreman
11. Industry or business: P. R. R.

FATHER
12. Name: James Harvell
13. Birthplace: Cecil Co

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Chester Harvell
Address: Conowingo, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 1, 1945 (month) (day) (year)
Cemetery or crematory: Harmony Chapel
Location: Liberty Grove, Md
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md
19. Feb 1, 1945 (Date rec'd by registrar) Emma E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/29, 1945, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 19..., to ..., 19...
and that I last saw h... alive on ..., 19...

Immediate cause of death	DURATION
Myocarditis	
No further information. Cor. Q.	
Due to: Physician did not treat patient;	
Due to: only saw him after death.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. L. Dodson M.D. (Medical Examiner of Cecil County)
Address: Perryville Md
M. D. or other
Date signed: 1/29/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00411

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 76 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Aiken
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Davis Patterson

3.(b) Social Security Number:

4. Sex: M
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Clara G. Hasson deceased
6.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): Sept. 6, 1868
8. AGE: Years: 76 Months: 4 Days: 25 If less than one day: ____ hrs. ____ min.
9. Birthplace: Perryville Cecil co. Md. (Town, county, and state)
10. Usual occupation: agent
11. Industry or business: Insurance
FATHER 12. Name: Henry M. Patterson
FATHER 13. Birthplace: Cecil co. Md.
MOTHER 14. Maiden name: Mary E. Smeltzer
MOTHER 15. Birthplace: Perryville Cecil co. Md.
16. Informant: Lee A. Patterson
Address: Perryville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 3, 1945 (month) (day) (year)
Cemetery or crematory: Hopewell
Location: Port Deposit Md. Rural
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Feb. 3 1945 (Date rec'd by registrar) Irene E. Daughaday Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31st 1945, at 1245 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1944 to Jan. 31 1945 and that I last saw h... alive on January 30 1945
Immediate cause of death: Hodgkins Disease — DURATION: 6 mo
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other
Address: Perryville Md Date signed: 2/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

00412

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:
County Cecil
City or town Conowingo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hours.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State New York County Orange
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Anthony Paul Pecka.
3. (b) Social Security Number

4. Sex M.
5. Color or race White
6.(a) Single, married, widowed, or divorced Single.
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Sept. 1899.
8. AGE: Years 45 Months 3 Days — If less than one day ... hrs. ... min.
9. Birthplace New Windsor N.Y.
(Town, county, and state)
10. Usual occupation Laborer.
11. Industry or business
FATHER 12. Name John Pecka
13. Birthplace Austria
MOTHER 14. Maiden name Mary Sofkey.
15. Birthplace Austria
16. Informant John Pecka N.Y.
Address 83 William St Newburgh
17. Burial Date thereof Jan 20 1945
(Burial, ~~cremation, or~~ removal. Which?) (month) (day) (year)
Cemetery or ~~crematory~~ Newburgh N.Y.
Location N.Y.
18. Funeral director W. E. Tyson
Address Rising Sun Md.
19. 1/18 — 19 45 L.M.M. Whinighton Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1945, at 5 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...
Immediate cause of death Acute Coronary Thrombosis. — DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE R. C. Dodson M.D. — Medical Examiner for Cecil County — M. D. or other
Address Rising Sun Md. Date signed 1-17-45

Permit issued 1-18-45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

00413

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: Bainbridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, institution, or street address where death occurred: US Naval Hosp-ital, NavTraCenter, Bainbridge, Md.
How long in hospital or institution? 18mdays

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Florida County: Volusia
City or town: Daytona Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. 512 Pine Haven,
(If rural, give LOCATION)
2.(a) If veteran, name war: WORLD WAR II ✓

3.(a) FULL NAME: William Duncan P R I N C E, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	NEGRO	MARRIED

6.(b) Name of husband or wife: Wife: Arlene McCollough PRINCE
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): February 28, 1921

8. AGE: Years	Months	Days	If less than one day
23	10	18	..... hrs. ..... min.

9. Birthplace: Columbia, South Carolina
(Town, county, and state)
10. Usual occupation: US NAVY
11. Industry or business

FATHER
12. Name: William Duncan PRINCE, Sr
13. Birthplace: Bennetsville, S.C.

MOTHER
14. Maiden name: —
15. Birthplace: Selma, Alabama

16. Informant: U.S. Naval Hospital, NavTraCen Bainbridge, Maryland.
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan. 17-45 (mouth) (day) (year)
Cemetery or crematory: To, Bethune Funeral Home
Location: Daytona Beach, Florida.
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md

19. Jan 17 1945 (Date rec'd by registrar) Irene E. Dunbar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 16 1945 at 11:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JANUARY 5 1945 to JAN 16 1945
and that I last saw h. A.M. alive on JANUARY 16 1945

Immediate cause of death	DURATION
Pulmonary Embolism	20 MIN
Due to: Broncho-pneumonia	16 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: Coalescent pneumonia
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Earl M. Haugrud M.D.
US NAVAL HOSPITAL BAINBRIDGE MD.
Address ..... Date signed 1/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06414

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Principio Furnace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

Principio Furnace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Principio Furnace, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Ella Louemma Meiker Reynolds

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Frank Asbury Reynolds

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 17, 1871

8. AGE:	Years	Months	Days	If less than one day
	73	7	7	..... hrs. ..... min.

9. Birthplace: Cecil County, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: William Meiker

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Mary Reynolds

15. Birthplace: Unknown

16. Informant: Raymond B. Reynolds (Son)

Address: Perryville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan 27-45 (month) (day) (year)

Cemetery or crematory: Principio Methodist

Location: Principio Furnace Md

18. Funeral director: Jasper A Grant

Address: North East, Md.

19. Jan 27 1945 (Date rec'd by registrar) Irma E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1945, at 2:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h.... alive on January 24 1945

	DURATION
Immediate cause of death: Grippe	17 days
Due to: Arteriosclerosis	20+ yrs.
Due to: Chronic Thyroid Toxicosis	18 yrs.
Chronic Endocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: V. H. McKnight M. D. or other

Address: Elkton - Md. Date signed: Jan 24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00415

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Principio Furnace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Principio Furnace

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Annie Rachel Rutter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6.(b) Name of husband or wife: James E. Rutter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 2, 1868

8. AGE: Years	Months	Days	If less than one day
76	9	22	..... hrs. ..... min.

9. Birthplace: Cecil co. Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER — 12. Name: Samuel P. White

FATHER — 13. Birthplace: Cecil Co. Md

MOTHER — 14. Maiden name: Myra K. Gamble

MOTHER — 15. Birthplace: Cecil Co. Md

16. Informant: Raymond White

Address: Principio Furnace, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 27 1945 (month) (day) (year)

Cemetery or crematory: Principio

Location: Principio Furnace, Md

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Jan 26 1945 (Date rec'd by registrar) Irene E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1945, at 6 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1940 to Jan. 24 1945

and that I last saw her alive on January 23 1945

Immediate cause of death	DURATION
Coronary Thrombosis Heart Disease	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other

Address: Perryville Md Date signed 1-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

06416

Reg. Diat. No. 90

1. PLACE OF DEATH:
County: Cecil
City or town: near Langford
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: near Langford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If roral, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Lause

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1874

8. AGE:

Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: Delaware (town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Morgan Lause
13. Birthplace: Delaware
MOTHER 14. Maiden name: Rachel Watson
15. Birthplace: Delaware
16. Informant: Mrs. William Lobey
Address: RFD Middletown Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 16, 1945 (month) (day) (year)
Cemetery or crematory: Hedgeville
Location: near Millington Md.
18. Funeral director: Edward Kellum
Address: Millington Md.
19. Jan. 17th 1945 (Date rec'd by registrar) Emma Burke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14th 1945, at 9 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10th 1945, to Jan 14th 1945
and that I last saw him alive on Jan 14th 1945

Immediate cause of death: Broncho Pneumonia	DURATION: 5 days
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G. L. Copeland M. D. ~~or other~~
Address: Millington Date signed Jan 16 "45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92nd)

CERTIFICATE OF DEATH

00417

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton R D 5
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton R D 5
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Henry Shaffer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Eva May Shaffer
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Feby 18 1879

8. AGE:

Years	Months	Days	If less than one day
69	10	29	hrs. min.

9. Birthplace: Elkton Cecil Md
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Jacharis Shaffer
13. Birthplace: Elkton Md
MOTHER 14. Maiden name: No information
15. Birthplace: No information
16. Informant: Mrs Henry Shaffer
Address: Elkton Md R 5
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 16 1945 (month) (day) (year)
Cemetery or crematory: Elkton Cemetery
Location: Elkton Md
18. Funeral director: H W Pusey
Address: Elkton Md
19. Jan 16 1945 (Date rec'd by registrar) J R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12 1945, at 1130 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4 1944, to Jan 12 1945
and that I last saw h[illegible] alive on Jan 12, 1945

Immediate cause of death	DURATION
Coronary thrombosis	
Due to: Chronic endocarditis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Morrison, M.D. M. D. or other
Address: Elkton, Md Date signed: 1-15-45

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00418

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 4 mo. 6 da.

Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? 3 yrs. 4 mo. 6 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 7 Wheeler Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: Word War I ✓

3.(a) FULL NAME: SINNOTT, Martin

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 25, 1888

8. AGE: Years	Months	Days	If less than one day
56	6	22	— hrs. — min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: —

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration Facility Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-17-45 (month) (day) (year)

Cemetery or crematory: New Cathedral Cemetery

Location: Baltimore, Md.

18. Funeral director: John J. Cowan & Son

Address: Baltimore, Md.

19. Jan. 17, 1945 (Date rec'd by registrar) Irene E. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16, 1945, at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 10, 1941 to January 16, 1945 and that I last saw him alive on January 16, 1945

Immediate cause of death	DURATION
Disease of the coronary arteries	3 yrs. 4 mo.
Due to: Arteriosclerosis, generalized	3 yr 4 mo
Due to:	
Other conditions: Psychosis with cerebral arterio-sclerosis; hemiplegia right, residuals right facial paralysis-aphasis, mixed type	3 yrs. 4 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A. E. Boellinger
A. E. Boellinger, Lt. Col., M.C. Clinical Director
M. D. or other
Veterans Administration
Address: Perry Point, Md. Date signed: 1-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on FILM No. G 92 MAR 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

00419

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: BAINBRIDGE, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Months
Hospital, institution, or street address where death occurred: US Naval Hospital, NavTraCenter, Bainbridge, Md.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County: Kings
City or town: Brooklyn,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1282 East 39th Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WORLD WAR II ✓

3. (a) FULL NAME: Calvin Warren S K I R V I N G

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Not married
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4, 1926

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
18 ~~19~~	6	14		

9. Birthplace: BROOKLYN, NEW YORK (Town, county, and state)
10. Usual occupation: US NAVY
11. Industry or business:
FATHER 12. Name: Alex SKIRVING
13. Birthplace: New York
MOTHER 14. Maiden name: Agnes BENNETT
15. Birthplace: New York
16. Informant: US Naval Hospital, NavTraCenter Bainbridge, Maryland.
Address:
17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) Jan (day) 20 (year) 1945
Cemetery or crematory: To Fairchild Funeral Chapel
Location: Brooklyn, New York
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Jan. 20 19 45 (Date rec'd by registrar) Irma E. Dunlop Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 January, 1945 19 at 11:45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 January 1945 to 18 Jan. 1945 and that I last saw h.i.m. alive on 18 Jan. 1945

Immediate cause of death	DURATION
Diabetic acidosis	15 hr.
Due to: Diabetes mellitus	1 day
Due to:	
Other conditions: Pneumonia, Lobar	1½ day

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Lobar pneumonia, pancreatic atrophy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry E. Dahl M. D. or other
Address: U.S. Naval Hosp. Bainbridge Date signed: 19 Jan. 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93

CERTIFICATE OF DEATH

(6420)

Reg. Dist. No. 85

1. PLACE OF DEATH:

County Cecil

City or town Outside Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Outside Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Richard Lewin Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14 1933

8. AGE:	Years	Months	Days	If less than one day
	11	2	18	hrs. min.

9. Birthplace Rising Sun, Cecil Co. Md. (Town, county, and state)

10. Usual occupation School Child

11. Industry or business

FATHER

12. Name Samuel Joseph Smith

13. Birthplace Rising Sun, Md.

MOTHER

14. Maiden name Sylvia Merl Mitchell

15. Birthplace Floyd Va.

16. Informant Samuel Smith

Address Rising Sun, Md., R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 4 1945 (month) (day) (year)

Cemetery or crematory Brookview

Location Rising Sun Md.

18. Funeral director J. E. Tyson

Address Rising Sun Md.

19. 1-4-45 (Date rec'd by registrar) Lemuel Thurston Registrar

Permit issued 1-4-45

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1945 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20 1940 to Jan 1 1945 and that I last saw h.... alive on Jan 1 1945.

	DURATION
Immediate cause of death: Chronic Myocarditis	5yrs
Due to:	
Due to: Rheumatic Fever	5yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. J. Brown, M.D. M. D. or other

Address Port Deposit Date signed 1/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

06421

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Union Hospital

How long in hospital or institution? 1-19-45 to 1-20-45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Warwick
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Samuel Stevens

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
Male	Black	

6.(b) Name of husband or wife Mother Agnes Briscoe

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12 - ~~1905~~ 1904

8. AGE: Years	Months	Days	If less than one day
40	11	22	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name James Stevens
13. Birthplace Md

MOTHER
14. Maiden name Agnes Hollingsworth
15. Birthplace Md

19. Informant Agnes Brisco
Address Warwick Md

17. Dale Cemetery Date thereof 1-20-45
(Burial, ~~Cremation, Removal~~? Which?) (month) (day) (year)
Cemetery or ~~Crematory~~ Dale Cemetery
Location Middletown Delaware

18. Funeral director G. Lester Daniels
Address Townsend Del

19. Jan 23 1945 H Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1945, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 1945, to January 20 1945 and that I last saw him alive on January 20 1945

	DURATION
Immediate cause of death Diabetes	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. T. Morrison, M.D.
M. D. or other

Address Elkton, Md Date signed 1-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

111422

Reg. Dist. No. 92

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Elkton County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 203 West Main St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Amelia Swenson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Olof Swenson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 2 - 1887

8. AGE: Years	Months	Days	If less than one day
57			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Wm Tucker
13. Birthplace: —

MOTHER
14. Maiden name: Emma Boyd
15. Birthplace: —

16. Informant: Hospital Records
Address: Elkton Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Jan 17 1945 (month) (day) (year)
Cemetery or crematory: Elkton cemetery
Location: Elkton Md

18. Funeral director: H W Pippin
Address: Elkton Md

19. Jan 15 1945 (Date rec'd by registrar) J R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14 1945 at 11 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1944 to Jan 14 1945 and that I last saw h[illegible] alive on Jan 14 1945

Immediate cause of death	DURATION
Gangrene of feet	
Due to: Diabetes mellitus	
Due to:	
Other conditions: Chronic hypertension nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Herbert Bates, M. D.
M. D. or other
Address: Elkton Md Date signed: 1/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (K42)

CERTIFICATE OF DEATH

00423

Reg. Diat. No. 91

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants give residence of mother)
State: Md. County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Bertha C Sutter

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife: George Sutter
6.(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): March 24 1887.

8. AGE: Years: 57 | Months: 9 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Philadelphia Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Henry Coleman
13. Birthplace: St Louis Mo.

MOTHER
14. Maiden name: Emma Driscoe
15. Birthplace: Philadelphia Pa.

16. Informant: George Sutter
Address: Chesapeake City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13 1945 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Chesapeake City Md RD
18. Funeral director: H. W. Pippin
Address: Elkton Md

19. Jan 11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 10 1945, at 2 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Drowned.	
& Frozen.	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 1-10-45
Where did injury occur? Canal (City or town) Chesapeake City (County) Cecil (State) Md
Injured at home, farm, industry, public place (where?): Canal.
Means of Injury: Injured at work?

23. SIGNATURE: R. E. Dodson M.D. Medical Examiner Cecil County
M. D. or other
Address: Perryville Md Date signed 1-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

00424

CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 66

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Cabesburg.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lula Jane Veals

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widowed

6.(b) Name of husband or wife: Elmore Veails Deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 22, 1878

8. AGE: Years	Months	Days	If less than one day
66	7	27	..... hrs. ..... min.

9. Birthplace: Port Deposit Cecil co. Md (Town, county, and state)

10. Usual occupation: House work

11. Industry or business: Own home.

FATHER — 12. Name: Steven Smith

FATHER — 13. Birthplace: Va.

MOTHER — 14. Maiden name: Sarah J. Jones.

MOTHER — 15. Birthplace: Port Deposit, Md.

16. Informant: Irene Cobert

Address: Port Deposit, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 21 1945 (month) (day) (year)

Cemetery or crematory: Cabesburg

Location: Port Deposit Md Rural

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Jan. 20 1945 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 18 1945 at 10 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-16- 1945 to 1-18 1945 and that I last saw h.. alive on 1-18-45 1945

Immediate cause of death	DURATION
Uremia Nephritis	1-18-45
Acute Cholecystitis	1-16-45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Claude L. Lawson M.D.

M. D. or other

Address: Havre de Grace Date signed 1-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

00425

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Bainbridge, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 DAYS.

Hospital, institution, or street address where death occurred: US Naval Hospital Naval Training Center, Bainbridge, Md.

How long in hospital or institution? 20 DAYS.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Arkansas County: Conway

City or town: Morrilton
(If outside city or town limits, write RURAL and give nearest town)

Street No. XXXXXXXXXXXX ROUTE I
(If rural, give LOCATION)

2.(a) If veteran, name war: WORLD WAR II ✓

3. (a) FULL NAME: Calvin Coolidge W H I T E

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	SINGLE

6.(b) Name of husband or wife: Not married

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 11-5-24

8. AGE: Years	Months	Days	If less than one day
20	2	20	..... hrs. ..... min.

9. Birthplace: Morrilton, Conway City Arkansas.
(Town, county, and state)

10. Usual occupation: US Navy

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: US NAVAL HOSPITAL, NAV TRA CEN
Address: BAINBRIDGE MARYLAND.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan 29 1945 (month) (day) (year)

Cemetery or crematory: ....

Location: Morrilton, Arkansas.

18. Funeral director: Lee a. Patterson & Son

Address: Perryville, Md.

19. Jan 27 19 45 Irma E. Daugherty (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 25. 1945 19 ..... at 1900 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4 1945 to Jan. 25 1945 and that I last saw him alive on Jan. 25, 1945 19 .....

	DURATION
Immediate cause of death: Chronic Nephritis	1 year.
Due to: Hypertension	—
Due to:	.....
Other conditions: Terminal Pneumonia	4 days.

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: chronic interstitial nephritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Harry S. Lourie, M. D. M. D. or other

Address: U.S.N.H. Bainbridge Md. Date signed: Jan. 26, 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING